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NASMD
National Association of State Medicaid Directors
an affiliate of the American Public Human Services Association

The Source of and for State Medicaid Directors

IN THIS ISSUE...

APHSA
American Public Human Services Association

HEADLINES FROM WASHINGTON

CMS Proposes Modifications to Provider Tax Regulation

On Friday, March 23 CMS published in the Federal Register a notice of proposed rulemaking (NPRM) on provider taxes under Section 1903(w) of the Social Security Act. The rule is intended to address the changes made in Section 403 of the Tax Relief and Health Care Act (TRHCA), P.L. 109-432. There is a 60 day comment period and NASMD encourages states to submit their individual comments by the May 22, 2007 deadline.

The proposed rule would change the existing regulation to conform to the TRHCA provisions. TRHCA codified that maximum amount that a state may receive from a health care related tax at six percent. According to the new statute, from January 1, 2008 through September 30, 2011, the safe harbor provider tax rate that ensures that a state does not violate the indirect guarantee component of the hold harmless provision will be temporarily reduced to 5.5 percent. On October 1, 2011, the cap on tax rates is scheduled to revert back to six percent.

In addition, the rule would clarify a number of issues in the original regulation that CMS has said have caused confusion. In so doing, CMS said the new language affords the agency broader flexibility in identifying relationships between provider taxes and payment amounts.

The clarifications CMS proposes include:

- Modify the "positive correlation test" to clarify that a state or other unit of government will violate this test if they impose a health care-related tax and also provide for a *direct or indirect* non-Medicaid payment and the payment amount is positively correlated to the tax amount or to the difference between the Medicaid payment and tax amount. CMS indicates that it will interpret "direct and indirect non-Medicaid payment" broadly.
- Clarify that a positive relationship can be identified even if it is not a mathematical relationship. For example, CMS will examine "extrinsic evidence," such as legislative history and circumstances surrounding the tax and grant programs, when identifying an indirect payment to establish the positive correlation.
- Standardize terminology for tax payment and payment amount.

Please feel free to contact Andrea Maresca at *amaresca@aphsa.org* or 202-682-0100 with any questions.

The NASMD summary of the regulation can be found at: *http://www.nasmd.org/issues/regulatory.asp* ♦

Spring 2007 NASMD Meeting • June 11-12, 2007

Sheraton Burlington Hotel & Conference Center, 870 Williston Road, Burlington, VT 05403, Tel: (802) 865-6600

This year's meeting will include a plenary session presented by Vermont Governor Jim Douglas. Additional presentation topics will include:

- State Children's Health Insurance Program
- CMS Update
- Long-Term Care Partnership Program
- Medicaid Integrity Initiatives
- State healthcare Reforms
- Presidential and Congressional Outlook

The Spring NASMD Meeting will include the following additional meetings:

- A special New Member Orientation will be held June 10 during which new Medicaid directors and Deputy Medicaid Directors will have the opportunity to meet with NASMD staff, the NASMD Executive Committee, and key federal officials.
- Territories representatives will have an opportunity to meet following the Spring NASMD Meeting on Tuesday, June 12.
- A Medicaid Tribal Caucus Meeting will be held Wednesday, June 13.
- Medicaid Transformation Grant states will also meet on Wednesday, June 13.

For preliminary meeting agendas and registration information please visit *http://www.nasmd.org/conf/conf.htm*. For additional information please contact Ashley Trantham *atrantham@aphsa.org*.

States, Congress Oppose Public Provider Regulation

March 19, 2007 marked the end of the public comment period on the proposed rule issued by CMS on cost limits for public providers, certified public expenditures, intergovernmental transfers, and related issues (CMS–2258-P). The American Public Human Services Association (APHSA) and the National Association of State Medicaid Directors (NASMD) submitted extensive comments outlining states' opposition to the regulation and the adverse impact it would likely have on Medicaid programs directly and indirectly on beneficiaries. The proposed rule has been criticized by a broad range of elected officials, state associations, provider groups and advocacy organizations as the most sweeping regulation issued by the Administration with far reaching consequences beyond those outlined in the regulation.

The six major areas of concern identified in APHSA and NASMD's letter include:

- Dismantling, or at a minimum significant disruption of, the current financing and reimbursement systems in many states;
- Creating an arbitrary distinction in reimbursement policies for providers based solely on whether they are public or private entities;
- Imposing a state mandate to comply with far reaching audit and review programs merely to demonstrate that they *do not employ* certain financing mechanisms that CMS now characterizes as inappropriate;
- Arbitrarily overturning principles that grant states the unique authority to define and create standards for entities classified as "units of government;"
- Proposing an unfeasible implementation timeframe; and
- Underestimating the regulatory impact in terms of scope, time, and resources at both the state and federal level.

On behalf of states, APHSA and NASMD reiterated that states share the federal government's strong commitment to protecting the fiscal integrity of the Medicaid program and are prepared to do so through federal-state initiatives and state-specific efforts.

MMI Bulletin

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However, the comments provided detail on the agency's proposed rule as a fundamentally flawed approach to achieve this stated goal.

The National Governors Association (NGA) and the National Conference of State Legislatures (NCSL), among many other groups also registered their opposition to the proposed regulation in official comment letters. According to the NGA the rule represents a significant cost shift to states and, "would further impede our progress in implementing reform options and expanding affordable health insurance coverage." NCSL emphasized that the rule would undermine the federal-state relationship and severely handicap the already fragile health care safety net.

A bipartisan group of 60 Senators submitted a strongly worded letter to Secretary Leavitt noting Congress' previous opposition to the proposal and urging him to withdraw the rule. The coalition of senators, led by Senators Jay Rockefeller (D-W.Va) and Gordon Smith (R-Ore.), noted that the fundamental changes in Medicaid's financing, such as those proposed in the rule, could only be adopted by Congress. In the House, a similar effort was led by Reps. Henry Waxman (D-Calif.), Janice Schakowsky (D-Calif.), James Walsh (R-N.Y.), and Peter King (R-N.Y.). The House letters was signed by 100 members and reflects concerns the National Governors Association expressed to Congress earlier this month as well concerns in APHSA's letter to the House and Senate budget committees.

During consideration of the fiscal year 2008 budget resolution, the Senate unanimously approved an amendment offered by Sen. Jeff Bingaman (D-N.M.) that would delay implementation of the rule proposed by the Centers for Medicare and Medicaid Services (CMS-2258-P) that would limit payments to public providers among other provisions as well as any other rule that would similarly result in cuts to the Medicaid and SCHIP programs. The amendment creates a deficit-neutral reserve fund to block the Medicaid regulation. Sen. Richard Durbin (D-Ill.) offered a similar amendment that was approved on an 18 to 11 vote by the Senate Appropriations Committee during consideration of the fiscal year 2007 emergency supplemental spending bill. The full Senate was expected to consider the measure in late March.

APHSA/NASMD continue to work with NGA in urging Congress to consider and pass legislation that would prevent CMS from implementing the proposed rule. The respective versions of the House and Senate FY 2008 budget resolutions and the FY 2007 supplemental measures will need to be reconciled during conference committees.

The APHSA/NASMD letter is available at: *http://www.nasmd.org/Home/home_news.asp*

The NGA, NCSL and Senate letters can be found at: *http://www.nasmd.org/issues/regulatory.asp* ♦

Senate, House Committees Hold Hearings on Health Care Coverage

On March 14, the Senate Finance Committee held a hearing on universal health care. Both committee Chairman Max Baucus (D-Mont.) and Ranking Member Charles Grassley (R-Iowa) voiced their support of the idea and their intentions to move legislation on the issue in the future. Although there was disagreement among both committee members and witnesses regarding exactly what the legislation should look like, there was general consensus on a few points, including: (1) the cost of universal health care would be between $70 and $100 billion per year; (2) providing universal coverage would involve much more than simply redirecting current health care spending; and (3) it would be more feasible to work with elements of the existing health care system as opposed to a "radical overhaul." Several witnesses agreed that legislation addressing coverage for the uninsured should precede legislation addressing rising health care costs, and that legislation expanding coverage for more Americans should be separate from that reauthorizing SCHIP. Sen. Grassley voiced his support for legislation that would include incentives for purchase of private coverage, rather than universal government-provided health care.

There was disagreement as to whether the move toward universal coverage would need to be accompanied by tax increases, and what other funding for the initiative would be. The hearing also examined features of the Massachusetts universal health care initiative and whether Congress should adopt the state's law on a national level.

More information, including witness testimonies, is available online at *http://finance.senate.gov/sitepages/hearing031407.htm.* ♦

Senate Considers FY07 Supplemental Appropriations Measure

On Thursday, March 29, the Senate approved the fiscal year 2007 supplemental spending bill. The measure includes language to provide sufficient

funding to avert federal funding shortfalls in the State Children's Health Insurance Program (SCHIP) for the remainder of fiscal year 2007. In addition, an amendment offered by Sen. Richard Durbin (D-Ill.) was approved by the committee and included in the base bill that passed the Senate. The amendment would prohibit the Centers for Medicare and Medicaid Services (CMS) from implementing for two years a final rule on CMS-2258-P, which addresses cost limits for public providers and related issues. The Durbin amendment also would prohibit CMS from issuing any regulation to restrict Medicaid graduate medical education (GME). As required by the "pay-as-you-go" rule, the amendment would off-set these changes by increasing the minimum Medicaid drug rebate to 20 percent, after March 31, 2007.

In addition, the measure includes $870 million in emergency funding for pandemic flu activities at HHS. Fifty million of the $870 million is for the vaccine compensation program. Some Senators also were working to include language that would extend the Transitional Medical Assistance (TMA) option beyond the current sunset date of June 30, 2007. ♦

Senate, House FY 2008 Budget Resolutions Inch Forward

Senate Budget Committee Chairman Kent Conrad (D-S.D.) released his budget blueprint for FY 2008, and the committee considered the measure on March 14 and 15. The proposal left out the various Medicaid and Medicare cuts included in the president's FY 2008 budget plan that was proposed earlier this year. Instead, the $2.96 trillion budget plan proposes an $18 billion increase in domestic discretionary spending over the administration's budget request, including increases for health insurance. Specifically, the initial budget plan called for the $15 billion over five years that some members of Congress are seeking for an expansion of SCHIP. It also included a "reserve fund" of $35 billion that could become available if members agree to spending reductions in other areas.

During floor debate, several Senators offered various health related-amendments that would establish principles for accessing some of the so-called "reserve funds" designated for SCHIP. Of the $50 billion designated for SCHIP by the committee, the Senate approved amendments that would provide for:

- $15 billion in the baseline for SCHIP that must be offset through Medicare savings;
- An additional $15 billion that is offset by reserving surplus in future years for SCHIP; and
- Another $20 billion is available in a deficit neutral "reserve fund" for which the Senate Finance Committee would have to find new offsets.

In addition, the Senate approved an amendment (59-40) offered by Sen. Gordon Smith (R-Ore) that would permit an increase in the tobacco tax and use all the revenues to offset the cost of reauthorizing SCHIP. Senators also unanimously approved an amendment expressing the sense of the Senate that SCHIP reauthorization was the top health care priority this year.

Similar to the measures offered during consideration of the FY 2007 supplemental spending bill, the full Senate approved an amendment offered by Sen. Jeff Bingaman (D-N.M.) that would delay implementation of the rule proposed by the Centers for Medicare and Medicaid Services (CMS-2258-P) that would limit payments to public providers among other provisions and any other rule that would similarly result in cuts to the Medicaid and SCHIP programs. The amendment creates a deficit-neutral reserve fund to block the Medicaid regulation.

Although the following amendments were defeated, they are expected to be debated again during reauthorization of the SCHIP program later this year:

- Senator Jim Bunning (R-Ky.) offered an amendment that would have placed restrictions on the use of the SCHIP reserve fund by prohibiting access to the funds if any limitations were made to state flexibility in SCHIP and Medicaid.
- Sen. John Cornyn (R-Tex.) offered an amendment to create a "reserve fund" for SCHIP that would have limited eligibility for SCHIP to children below 200 percent of poverty and limited state flexibility to cover parents and childless adults.
- Sen. Saxby Chambliss (R-Ga.) offered an amendment to create a reserve fund for SCHIP reauthorization that prohibited states from covering parents and childless adults. It permitted states to offer supplemental dental and mental health benefits for children enrolled in SCHIP.
- An amendment by Sen. Orrin Hatch (R-Utah) would have provided for a reserve fund for expanding SCHIP and other Medicaid changes provided that no reductions in benefits were made to Medicare Advantage enrollees or coverage options in Medicare.

The House fiscal year 2008 budget resolution also provides for $50 billion for reauthorization of SCHIP. The Ways and Means Committee must first identify funding offsets before Congress can access this funding. The House and Senate budget resolutions are non-binding measures, but they do provide a blueprint for the issues and priorities Congress will address this year. The House and Senate will attempt to reconcile differences in their measures during a conference committee in the weeks ahead.

More information on the budget proposal can be found at *http://budget.senate.gov/democratic/* ♦

Could More Help from Medicare be on the Way?

On March 15, 2007, Rep. Lloyd Doggett (D-Texas), introduced new legislation that seeks to enroll millions more low-income beneficiaries in the Medicare Part D prescription drug program. The measure (HR 1536) would revise the current asset test that disqualifies an estimated 3.27 million low-income individuals from receiving the extra help. Rep. Stark, chairman of the House Ways and Means Health Subcommittee, indicated he plans to include the bill as part of broader Medicare legislation that he plans to bring up later this year, although a specific timetable has not yet been established.

Specific provisions of the legislation include:

- Give "limited access" by the Centers for Medicare and Medicaid Services (CMS) to Internal Revenue Service data to identify people eligible for the extra help.
- Provide for multiple "clearly worded" notices to beneficiaries and other outreach efforts.
- End the current practice of counting financial assistance children give their parents paying for utility bills or groceries when adding up their incomes to determine if they qualify for the extra help.
- Revise the asset test so individuals could have assets of up to $27,500 and couples assets up to $55,000. The cutoff now is $11,710 for individuals and $23,410 for couples.

Although the Congressional Budget Office has not yet issued a cost estimate, one challenge the congressmen will face is finding offsets to pay for measure. Rep. Stark has made it clear that he considers cutting payments to Medicare managed care plans as one option to pay for this and other priorities. According to Rep. Doggett's office, Senators Gordon Smith (R-Ore.) and Jeff Bingaman (D-N.M.) have expressed interest in introducing similar legislation. ♦

House Holds Hearing on Medicare Advantage Programs

On March 21, the House Ways and Means Health Subcommittee held a hearing on Medicare Advantage Programs, during which committee members and speakers examined the payment method used for Medicare Advantage plans. The CBO estimates that the government could save nearly $65 billion over five years if Medicare Advantage payments were brought to the same level as traditional Medicare. The Medicare Payment Advisory Commission (MedPac) estimates that the plans get two cents more on the dollar than basic Medicare plans. Leslie Norwalk, acting administrator of CMS, provided testimony that defended the higher payments for the plans. She indicated that the costs go toward added benefits, such as disease management, which are not provided under traditional Medicare.

To view the witnesses' testimony, please visit *http://waysandmeans.house.gov/hearings.asp?formmode=detail&hearing=543&comm=1.* ♦

Senate, House Committees Hold Hearings on Health Care Coverage

On March 14, the Senate Finance Committee held a hearing on universal health care. Both committee Chairman Max Baucus (D-Mont.) and Ranking Member Charles Grassley (R-Iowa) voiced their support of the idea and their intentions to move legislation on the issue in the future. Although there was disagreement among both committee members and witnesses regarding exactly what the legislation should look like, there was general consensus on a few points, including: (1) the cost of universal health care would be between $70 and $100 billion per year; (2) providing universal coverage would involve much more than simply redirecting current health care spending; and (3) it would be more feasible to work with elements of the existing health care system as opposed to a "radical overhaul." Several witnesses agreed that legislation addressing coverage for the uninsured should precede legislation addressing rising health care costs, and that legislation expanding coverage for more Americans should be separate from that reauthorizing SCHIP. Sen. Grassley voiced his support for legislation that would include incentives for purchase of private coverage, rather than universal government-provided health care.

There was disagreement as to whether the move toward universal coverage would need to be accompanied by tax increases, and what other funding for the initiative would be. The hearing also examined features of the Massachusetts universal health care initiative and whether Congress should adopt the state's law on a national level.

More information, including witness testimonies, is available online at *http://finance.senate.gov/sitepages/hearing031407.htm*.

On March 15 the House Committee on Education and Labor Subcommittee on Health, Employment, Labor, and Pensions held a hearing on expanding health coverage through employer-provided benefits. No details on the hearing were available as of press time. More information will soon be available at *http://edworkforce.house.gov/*. ♦

SMD Released with Guidance on False Claims Recovery

On March 22, CMS released a Dear State Medicaid Director (SMD) letter, accompanied by a previously released "Frequently Asked Questions" (FAQ) list providing guidance related to the "Employee Education about False Claims Recovery." The FAQ list is intended as a supplement to the SMD letter issued on December 13, 2006. Along with the letter and FAQ list, CMS sent a letter providing a description of the Federal False Claims Act from the Department of Justice.

The SMD letter is available online at *http://cwd.aphsa.org/publications/FalseClaimsSMD.PDF*.

The "Frequently Asked Questions" list is available at *http://cwd.aphsa.org/publications/False-Claims-FAQ.pdf*.

NASMD Unveils New web site

Please visit **www.nasmd.org** and take a look at our newly re-designed web site. We hope you will find the new look and feel more user-friendly. For questions/comments please contact Ashley Trantham at *atrantham@aphsa.org*.

The Department of Justice description of the False Claims Act is available at *http://cwd.aphsa.org/publications/False-Claims-Description.pdf*. ♦

House Subcommittee on Oversight and Investigations Holds Hearing on Continuing Health Care Problems in the Wake of Hurricane Katrina

On March 13, the House Energy and Commerce Oversight and Investigations Subcommittee held a hearing to examine the continuing health care needs and problems in the regions most affected by Hurricane Katrina. The hearing consisted of three panels, made up of representatives from federal, state, and local government agencies; local health care systems, centers, and providers from the Gulf region; and policy experts. The witnesses emphasized that there are still major problems facing the health care systems in the region 18 months after the storm, including provider shortages, lack of hospital beds, inadequate mental health services, and bureaucratic barriers preventing much-needed financial assistance. Subcommittee members and witnesses also discussed the federal assistance provided to the region for health care, and disagreement ensued about the level of adequacy of federal aid to the region, and of the adequacy of the accounting for that aid.

More information is available online at *http://energycommerce.house.gov/cmte_mtgs/110-oi_hrg.031307.katrina_health_care.shtml*. ♦

APHSA Council Meeting Rescheduled for June 1-5

APHSA would like to announce the dates for the rescheduled Spring Council Meeting, which was postponed due to a viral outbreak at the hotel. The Spring APHSA Council Meeting will take place at the Hyatt Regency Washington on Capitol Hill on June 1-5, 2007. The room rate will be the same as was planned for the original dates. We invite and encourage you to save these tentative dates for the rescheduled conferences:

- New State CEO Orientation—Sat., June 2
- APHSA Conference—Sun., June 3 to Tues., June 5, 2007

The Hyatt Regency Crystal City has also agreed to reimburse APHSA Spring Conference registrants for airline and rail change fees or penalties incurred as a result of the hotel closing.

For more information, please visit our web site at *http://www.aphsa.org/Home/Doc/Rescheduling_Revised_Memo_March_7_2007.pdf.* ♦

CITIZENSHIP UPDATE

CMS Announces Access to Medicaid for all Low-Income Newborns

On March 20, CMS announced in a press release that it will provide equal access to Medicaid for low-income newborns. Leslie Norwalk, acting administrator of CMS, announced that babies born in the U.S. whose deliveries are covered by Medicaid will remain eligible for Medicaid for up to a year after their birth. Based on this announcement, all newborns whose mothers are on Medicaid at the time of the child's birth, whether they are receiving emergency services only or full Medicaid services, will be given the "deemed" status and receive Medicaid for up to one year from the date of birth. CMS further stated that an interim final rule containing clarification on this issue should be issued shortly. To view the press release, please visit *http://cwd.aphsa.org/publications/Newborn%20Medicaid.pdf.*

Meanwhile, Sen. Charles Grassley, Rep. Jose Serrano (D-N.Y.), and Rep. Gene Green (D-Tex.) all introduced different versions of legislation making technical corrections to the Medicaid citizenship documentation requirements for eligibility for newborns contained in the Deficit Reduction Act of 2005 (DRA). All versions seek to address the problem created by the DRA of "erroneously inhibiting" access to Medicaid.

Senator Jeff Bingaman (D-N.M) also offered a comprehensive measure, S. 909, that would make citizenship verification a state option. Specifically, states would be permitted to determine when and to what extent citizenship verification is required of U.S. citizens. States would also be permitted to utilize the standards most appropriate to their population as long as such standards were no more stringent than those currently used by the Social Security Administration and include Native American tribal documents when appropriate. The legislation also seeks to:

- Ensure that individuals are afforded sufficient time to provide citizenship documentation utilizing the same reasonable time period standard that is available to legal immigrants to provide satisfactory evidence of their immigration status.
- Protect children who are U.S. citizens by virtue of being born in the United States from being denied coverage after birth because of citizenship verification requirements.
- Clarify ambiguities in federal law to ensure that these citizen children, regardless of the immigration status of their parents, are deemed eligible to receive Medicaid services for one year.
- Ensure that the thousands of citizen children and adults, who were erroneously denied Medicaid because of citizenship verification requirements, may receive retroactive Medicaid eligibility for the coverage they were inappropriately denied.

To view the language of the bills, please visit *http://thomas.loc.gov/home/bills_res.html.* The bill numbers are S. 751, H.R. 210, and H.R. 1238, respectively. ♦

Washington Governor Signs Bill to Expand Coverage for Children

On March 13, Washington Governor Christine Gregoire (D) signed a bill that would expand health coverage to 38,000 state residents ages 19 and under within the next two years. The bill creates a new state-sponsored health care plan to cover children in families with incomes up to 250 percent of the federal poverty level (FPL). Starting in 2009, the plan will expand coverage to children in families up to 300 percent FPL. In addition, families with annual incomes between $40,000 and $60,000 can buy into the plan, and families with access to employer-sponsored insurance can receive assistance in paying the premium to obtain coverage for dependents.

The program is estimated to cost $60 million in state and federal funding.

More information on the bill is at *http://apps.leg.wa.gov/billinfo/summary.aspx?bill=5093&year=2007.* ♦

NEWS FROM THE STATES

Arizona Governor Discusses Electronic Health Records at Summit

On March 20, Arizona Governor Janet Napolitano (D) addressed attendees of the Healthe Connection Summit in Phoenix. The attendees were comprised of health care professionals, consumers, and health care executives. Governor Napolitano discussed Arizona's five-year strategy for building and implementing the electronic exchange of health records, which involves forming a strong partnership between the state, providers, and major employers, while protecting privacy during the electronic exchange of health care information.

To view the press release, please visit *http://www.governor.state.az.us/dms/upload/NR_032007_HealtheRelease.pdf*

Bill to Extend Medicaid Coverage to Workers with Disabilities Passes in Missouri Legislature

On February 13, the Missouri Legislature voted 151-2 to pass a bill that would extend Medicaid coverage or reduce costs for workers with disabilities, many of whom lost coverage in 2005. Residents with disabilities earning less than $35,735 from a job that withholds Medicare and Social Security taxes who qualify for deductions that lower their net annual income to $8,679 would be eligible to pay for Medicaid benefits on a sliding scale. Premiums would range from 4% to 7% of the workers income.

More information is available online at *http://www.house.mo.gov/bills071/bills/HB39.HTM.* ♦

Governor Schwarzenegger and HHS Secretary Leavitt Meet to Expand Health IT

On March 14, California Governor Arnold Schwarzenegger (R) convened a meeting in San Diego with HHS Secretary Leavitt to sign an executive order to strengthen state mandates to adopt health information technology (HIT), and make information on prices and care quality more transparent while increasing accountability for private and public healthcare systems.

Governor Schwarzenegger's executive order is similar to the federal initiative promoted by the administration. The goal of the order is to reduce medical errors, improve patient care, and keep medical costs in balance by providing accurate and updated information to patients wherever they are receiving care. In sum, the executive order promotes the following: (1) establishes a cabinet-level public/private sector workgroup to develop a strategy to improve the quality, transparency and accountability of healthcare delivery in California by December 31, 2007; and (2) expands the Office of Statewide Health Planning and Development's ability to collect data on the results of health treatment, and on costs and pricing for consumers, employers, health plans and providers. It also promotes ways to align incentives between health plans and providers to improve quality and efficiency. ♦

Georgia Announces Temporary Fix for PeachCare Funding Shortage

This week, Georgia Governor Sonny Perdue (R), Lt. Governor Casey Cagle, and Speaker Glenn Richardson announced a temporary funding solution to address the state's shortage in funds for the PeachCare program, Georgia's SCHIP. The state announced that it will temporarily borrow funding from the Medicaid budget to cover PeachCare until Congress appropriates funding for SCHIP. All borrowed funding would be repaid to Medicaid once the state receives the appropriated funds. ♦

Illinois Governor Proposes Health Coverage Expansion

On March 3, Illinois Gov. Rod Blagojevich (D) released a plan to expand access to health insurance to uninsured state residents. "Illinois Covered" would require every insurer to offer a standardized, comprehensive insurance policy to the state's 1.4 million uninsured residents, regardless of pre-existing medical conditions. The plan has three parts, one focuses on childless adults with annual incomes below the federal poverty level who are ineligible for Medicaid, another to offer low-cost private insurance plans to residents without employer-sponsored coverage, and a third component that would assist in paying premiums for existing employer sponsored coverage. The governor's plan also would expand eligibility for existing programs that serve some parents and people with disabilities who are returning to work.

The plan was based in part on recommendations from a legislative task force. More information on "Illinois Covered" is available at *http://www.illinois-covered.com/*. ♦

Washington Governor Files Lawsuit Over Medicaid Coverage of Newborns

On March 5, Governor Gregoire (D) announced that Washington will file suit against the federal government to protect the rights of newborn citizens to health care coverage under Medicaid. Governor Gregoire stated that every citizen born on U.S. soil is a U.S. citizen and thus they should not be denied the right to health care coverage. Washington estimates that nearly 8,000 infant citizens will be affected by these rules and the delay in health care coverage or lack of coverage will cost more money. Washington will not implement this policy for newborns until the lawsuit has been resolved. ♦

Texas State Senate Unveils Medicaid Reform Proposal

Late last week, Texas State Senator and chairwoman of the Senate Health and Human Services Committee Jane Nelson (R) unveiled a proposal that would revamp the Texas Medicaid program to both extend coverage to more uninsured residents and control growing Medicaid costs. The proposal includes a plan to move more Texans to private insurance by providing the option to opt-out of Medicaid in exchange for the state paying a portion of employer-based coverage costs. The proposal also includes initiatives to help beneficiaries lose weight, quit smoking, and participate in disease management; co-pays for non-emergency visits to hospital emergency rooms; and a pilot program for health savings accounts. In addition, the proposal includes mechanisms to reduce fraud and abuse.

Sen. Nelson indicated that a federal waiver would be needed to implement some of the proposed changes. ♦

SCHIP NEWS

NASMD Letter on SCHIP Reauthorization

On March 7, the American Public Human Services Association (APHSA) and the National Association of State Medicaid Directors (NASMD) sent a letter to Speaker of the House Nancy Pelosi (D-Calif.), House Majority Leader John Boehner (R-Ohio), Senate Majority Leader Harry Reid (D-Nev.), and Senate Minority Leader Mitch McConnell (R-Ky.) outlining the organizations' principles for reauthorization of the SCHIP. The letter urges the leaders to ensure Congress moves quickly but thoroughly in its efforts to reauthorize SCHIP. The letter also addressed the shortfalls states will experience in fiscal year 2007 stating, "the looming shortfalls threaten the sustainability of states' SCHIP programs this year, and they also create an uncertainty in the program to the detriment of states' provider networks and SCHIP enrollees." The letter and principles can be viewed at *www.nasmd.org*. ♦

GAO Releases Study on States' SCHIP Enrollment and Spending Experiences

On Thursday, March 1 the Government Accountability Office (GAO) published a study on SCHIP. The GAO identified several trends regarding SCHIP programs. Forty-one states opted to cover children in families with incomes at 200 percent of the federal poverty level (FPL) or higher, with seven of these states covering children in families with incomes at 300 percent of FPL or higher.

In addition, 39 states required families to contribute to the cost of their children's care in SCHIP programs through a cost-sharing requirement, such as a premium or co-payment; 11 states charged no cost-sharing. GAO also identified 14 states that had waivers in place to cover adults in their programs; these included parents and caretaker relatives of eligible Medicaid and SCHIP children, pregnant women, and childless adults.

GAO indicated that as Congress addresses reauthorization, issues to consider include: 1) maintaining flexibility within the program without compromising the primary goal to cover children; 2) considering the program's financing strategy, including the financial sustainability of public commitments; and 3) assessing issues associated with equity, including better targeting SCHIP funds to achieve certain policy goals more consistently nationwide.

To view the report, please visit the GAO web site at *http://www.gao.gov/new.items/d07558t.pdf*. ♦

MENTAL HEALTH CORNER

Kennedy and Ramstad Introduce Mental Health Parity Bill

On March 7, Reps. Patrick J. Kennedy (D-R.I.) and Jim Ramstad (R-Minn.) introduced the Paul Wellstone Mental Health and Addiction Equity Act (H.R. 1367). The bill's purpose is to improve access to mental health and addiction treatment and prohibit health insurers from placing discriminatory restrictions on treatment. The legislation is cosponsored by a bipartisan majority of 256 members of Congress.

The bill expands the Mental Health Parity Act of 1996 by requiring group health plans that offer benefits for mental health and addiction to do so on the same terms as care for other diseases. The legislation prevents plans from charging higher co-payments, co-insurance, deductibles, and maximum out-of-pocket limits as well as imposing lower day and visit limits on mental health and addiction care.

According to the Government Accountability Office, nearly 90 percent of plans impose such financial limitations and treatment restrictions on mental health and addiction care despite scientific research documenting the biological, genetic, and chemical nature of these diseases, and the effectiveness of treatment. Both the House and Senate versions of the bill apply to group health plans of 50 or more people.

In February, the Senate Health, Education, Labor and Pensions Committee approved similar legislation, The Mental Health Parity Act of 2007, sponsored by Senators Edward M. Kennedy (D-Mass.), Pete Domenici (R-N.M.), and Michael Enzi (R-Wyo.). Among the differences is that the House bill requires health plans offering mental health benefits to cover the same mental health and addiction disorders that are included in the health plans used by members of Congress, while the Senate bill has no such provision. The bills also differ in how they impact related state laws.

For more information on mental health parity, please visit *http://www.mhlg.org/page18.html.* ♦

CBO Scores Mental Health Parity Act of 2007

On March 20, CBO released cost estimates for the Mental Health Parity Act of 2007 (S. 558). The bill, introduced last month, "would prohibit managed care group health plans and group health insurance issuers that provide both medical and surgical benefits and mental health benefits from imposing treatment limitations or financial requirements for coverage of mental health benefits that differ from those used for medical and surgical benefits." Current law requires a more limited form of parity between mental health and medical and surgical coverage. That mandate will expire at year's end. Consequently, S. 558 would both extend and expand the existing mandate requiring mental health parity.

According to CBO estimates, requirements for issuers of group health insurance would apply to managed care plans participating in the Medicaid program by increasing the Medicaid payments to managed care plans by 0.2 percent. Consequently, the estimate for the federal outlay to Medicaid would be increased by $280 million over the period of 2009 through 2012, and by $790 million between 2009 and 2017. The bill's requirements for issuers of group health insurance would apply to managed care plans in the Medicaid program. In addition, "for plans that offer mental health benefits through a network of mental health providers, the requirement for parity of benefits would be established by comparing in-network medical and surgical benefits with in-network mental health benefits, and comparing out-of-network medical and surgical benefits with out-of-network mental health benefits. The provision also would apply to benefits for any mental health condition that is covered under the group health plan."

The bill would not require plans to offer mental health benefits, nor would it require that those plans cover all types of mental health services or ailments if the plan covered any mental health services or ailments. However, laws in some states require that plans cover those benefits, which affects the potential impact of S. 558 on health plan premiums.

CBO's estimate of the Mental Health Parity Act of 2007 can be found online at *http://www.cbo.gov/ftpdocs/78xx/doc7894/s558.pdf.*

The text of S. 558 is available online at *http://thomas.loc.gov/.* ♦

SAMHSA Makes State Estimates of Substance Use Available

The Substance Abuse and Mental Health Services Administration (SAMHSA) has released a report entitled *State Estimates of Substance Use from the 2004-2005 National Surveys on Drug Use and Health.* The report includes estimates of illicit drug use, alco-

hol use, tobacco use, substance dependence, abuse, treatment need, and mental health functioning for the civilian, non-institutionalized population of people 12 and older. Illicit drug use ranged from a low of 5.9 percent in Iowa to high of 12.2 percent in Alaska, and demonstrated a national decrease in youth age 12 to 17 from 10.9 percent (2003-2004) to 10.3 percent (2004-2005). There was a slight increase in all people using alcohol in the rate of past month alcohol use, from 50.2 to 51.1 percent, but a decrease among youth age 12 to 17 from 17.7 to 17.1 percent. Rates of dependence on alcohol and illicit drugs remained about the same, though there was an increase among dependence on illicit drugs among 18 to 25 year olds from 5.4 to 5.7 percent. About 11.6 percent of the population experienced serious psychological distress (SPD), with the highest rate at 15.3 percent in West Virginia and the lowest rate at 9.8 percent in Hawaii.

The full report is available at *http://oas.samhsa.gov/2k5state/pdf/2k5state.pdf.* ♦

SAMHSA Report Examines Health Insurance and Substance Use Treatment

A new report from SAMHSA's Office of Applied Studies looks at health insurance coverage and the need for substance use treatment among adults. The report uses data from the 2004 and 2005 National Surveys on Drug Use and Health, in which individuals (or their family members) were asked about whether they have health coverage, the type of health coverage they receive, whether they receive substance abuse treatment coverage through their insurance, and substance use and dependence issues.

Key findings from the report include that adults in need of substance use treatment services were less likely to have health insurance than adults who do not need treatment services, at 74.4 percent a compared to 86.6 percent respectively. In addition, the majority of respondents indicated they had private health insurance (about 70.5 percent of all respondents).

The full report is available online at *http://www.oas.samhsa.gov/2k7/insurance/insurance.htm.* ♦

SAMHSA Announces Opportunity for Mental Health Data Infrastructure Grant for Quality Improvement

The Substance Abuse and Mental Health Services Administration's Mental Health Data Infrastructure Grant for Quality Improvement is accepting applications for 2007 from State Mental Health Agencies who receive the Mental Health Block Grant. Fifty-eight awards are expected to be granted with maximum funding per award at $142,000 for states and $71,100 for territories for up to three years. The purpose of the grants is to fund State Mental Health authorities to improve data infrastructure for reporting and planning. The application is due on May 3, 2007.

For additional information please visit *http://www.samhsa.gov/Grants/2007/sm_07_012.aspx.* ♦

COURT CASES

U. S. District Court for the Western District of Missouri

***Lankford v. Sherman*, No. 05-CV-C-DW**
(W.D. Mo. March 2, 2007)

On March 2, this court enjoined Missouri's Director of Social Services from enforcing a regulation that excludes a number of categorically-needy Medicaid recipients from receiving certain durable medical equipment (DME) benefits. Plaintiffs do not have an absolute right to DME, however, since Missouri elected to provide DME the Plaintiffs have a right to have the federally funded DME program comply with Medicaid's reasonable standards requirement. The court further concluded that the exceptions process did not provide a reasonable manner to obtain non-covered items. To view the opinion please visit *http://www.nasmd.org/resources/court_cases.asp.* ♦

Massachusetts Supreme Judicial Court

***Salisbury Nursing & Rehab. Ctr. Inc. v. Division of Admin. Law Appeals*, No. SJC-09646 (Mass. Feb. 15, 2007)**

On February 15, this court upheld the validity of regulations established by the Division of Health Care Finance & Policy to transition from a "prospective rates" to "standard rates" system for calculating Medicaid payment rates for nursing homes. The judge ruled that the application of the Total Payment Adjustment (TPA) did not subject Plaintiff, Salisbury to an illegal base year, and that the rate setting regulations issued by the Division of Administrative Law Appeals were not arbitrary, capricious, or contrary to law. To view the opinion please visit *http://www.nasmd.org/resources/court_cases.asp.* ♦

Missouri Court of Appeals

***Department of Social Servs., Div. of Med. Servs. v. Little Hills Healthcare, L.L.C.*, No WD 66879 (Mo. Ct. App. Feb. 20, 2007)**

On February 20, this court reversed an administrative decision finding that a hospital was entitled to an additional $1.8 million in direct Medicaid payments. Initially the facility filed a complaint with the Commission arguing that the Division of Medical Services' (DMS) computation of its Medicaid reimbursement for SFY2004 was arbitrary resulting in a $1.8 million underpayment. The Commission found that DMS failed to promulgate a rule for the estimation of Medicaid days for purposes of Medicaid payments. However, this court reversed, and concluded that DMS was not required to promulgate such a rule for estimating Medicaid patient days. This case was remanded to the Commission to determine whether the DMS abused its discretion in estimating the hospital's Medicaid days for the year at issue. To view the opinion please visit *http://www.nasmd.org/resources/court_cases.asp.* ♦

REPORTS AND PUBLICATIONS

NASMD Releases Survey on Long-Term Care Partnership Programs

NASMD released their survey results on the implementation of Long-Term Care Partnerships in March. Thirty-six states responded to this survey and 27 states indicated that they have or will submit a State Plan Amendment (SPA). Two additional states are considering submission of a SPA. Seventeen states plan to submit their SPAs in 2007 and three states plan to do so in 2008. Fifteen states believe their program will be fully operational within one year. To view the survey in its entirety please visit: *http://www.nasmd.org/issues/docs/LTCPP_March_2007_Survey_Results.doc.* ♦

Government Accountability Office (GAO) Releases Report on Health Care and Hurricane Katrina

On February 28, the GAO released a report on the funds that were allocated for health care costs related to Hurricane Katrina. The Deficit Reduction Act (DRA) appropriated $2 billion and the Centers for Medicare & Medicaid Services (CMS) was in charge of allocating these funds to the states affected by Hurricane Katrina. This report provides an analysis on the manner in which CMS allocated the funds, the extent to which the states used the funds, and whether the states that received the funds are in need of additional funds. The report found that both Louisiana and Texas are concerned about their ability to meet future health care needs after the DRA funds are expended. To view the report in its entirety please visit *http://www.nasmd.org/resources/publications.asp.* ♦

Alliance for Health Reform Issues Brief on Long-Term Care Partnerships

The brief *Long-Term Care Partnerships: An Update* includes information from the Alliance for Health Reform November 2006 briefing. Long-Term Care Partnerships, with support from the Robert Wood Johnson program, started with four state programs in 1987; by 2006 Medicaid reported that 22 states were interested in forming partnerships. This brief contains overviews of the role of private insurance, how Long-Term Care Partnership Programs work, post-DRA changes to the programs, issues related to inflation, goals of the programs and whether or not they have been met, and possible state improvements. As more states develop Partnership programs new challenges arise, such as increased differences in programs and how that effects portability should a purchaser move from one state to another. To date, progress towards meeting program goals has been mixed, including the goals of attracting moderate-income purchasers and producing cost savings for Medicaid.

States with questions on LTC Partnerships should contact Ilana Cohen at *icohen@aphsa.org*. The brief is available at *http://www.allhealth.org/publications/Long-term_care/Long_Term_Care_Partnerships_53.pdf*. ♦

Urban Institute Issues Report on How Children Fare in the Federal Budget

The Urban Institute recently released a report entitled *Kids Share 2007: How Children Fare in the Federal Budget*. The report includes an analysis of historical trends, current issues, and predictions for the future related to federal government spending on children (including about 100 federal programs in eight major categories: income security, nutrition, housing, tax credits and exemptions, social services, education, and training). Though federal spending on children, adjusted for inflation, grew from $53 billion in 1960 to $333 billion in 2006, the share of the economy rose from just 1.9 percent to 2.6 percent of the economy. Considering just domestic spending, the children's share declined from 20.1 to 15.4 percent. Over the next ten years, federal spending on children is expected to shrink compared to programs that have built-in growth.

The report is available at *http://www.urban.org/UploadedPDF/411432_Kids_Share_2007.pdf*. ♦

Study Finds Uninsured Receive Less Care and Have Worse Outcomes than Patients with Insurance

A new study, published in the *Journal of the American Medical Association* (JAMA) and commissioned by the Kaiser Family Foundation, concludes that the uninsured, compared to people with insurance, receive less care and have worse outcomes after an accident or the onset of a chronic condition. The study was based on eight years of data and included the findings that the uninsured were more likely to report not fully recovering or being treated seven months after an accident, and those with new chronic conditions reported worse health status than the insured. Following an accident, 78.8 percent of people without insurance were likely to receive medical care compared to 88.7 percent of people with insurance. Following the development of a new chronic condition, 81.7 percent of the uninsured received medical care compared to 91.5 percent of the insured.

More information and free access to the JAMA article can be found at *http://www.kff.org/uninsured/kcmu031407oth.cfm*. ♦

NASMD Position Announcement

Program Director
Center for Workers with Disabilities

The American Public Human Services Association (APHSA) seeks experienced candidates to fill the program director position of its Center for Workers with Disabilities. The Center for Workers with Disabilities is a special project of APHSA and its affiliate the National Association of State Medicaid Directors. Responsibilities include leading research on disability policy issues, grant management, technical assistance, staff support to member agencies, and writing for various publications. The director will be responsible for issues areas that include behavioral health, disability, aging, and long-term care. The director will lead a team that assists in providing states with information regarding Medicaid programs and policies in other states. Responsibilities will include: state to state exchange of information, contributing to periodic APHSA and NASMD Issue Briefs. Strong writing and communication skills and knowledge of health and disability policy required. State Medicaid and disability policy experience desirable. Ideal candidate will have advanced degree and 10-15 years of experience in specific policy area and be willing to travel. Individuals with disabilities encouraged to apply. Email/fax resume with cover letter to: APHSA/CWD director, 810 First Street, N.E. #500, WDC 20002 or *jobs@aphsa.org* or Fax: 202-289-6555. EEO/AA ♦

AVAILABLE GRANTS

High Risk Pool Seed Grants Available

CMS announced the availability of seed grant funds for eligible states that did not have a qualified high risk pool prior to February 10, 2006 to assist states to create and initially fund qualified high risk pools.

Section 6202 of the DRA, entitled "State High Risk Health Insurance Pool Funding," extends funding of grants under section 2745 of the Public Health Service Act (PHS Act) through the FY 2006 by authorizing $15 million for seed grants to assist states to create and initially fund qualified high risk pools. CMS obligated and awarded $2.45 million out of the $15 million in seed grants in FY 2006. The remaining $12.55 million balance in un-obligated seed grant funds is available through September 30, 2007.

The application announcement is available at www.grants.gov. Applications should be submitted electronically through grants.gov. The Funding Opportunity Number is HHS-2007-CMS-HRP-0006. To apply, go to *www.grants.gov*. For questions on the application process contact grants.gov at 1-800-518-4726 or *support@grants.gov*.

CMS is requesting a letter of intent to apply by May 30, 2007. The deadline for all applications is June 29, 2007. ♦

State Agency Partnerships Grant Available for Promoting Child and Adolescent Mental Health

Health Resources and Services Administration (HRSA) published a grant opportunity for State Agency Partnerships for Promoting Child and Adolescent Mental Health Programs (SAP-PCAMH) to "improve the ability of States to comprehensively and effectively address the mental health and psychosocial needs of all school-aged children" through partnerships with programs such as Maternal and Child Health, Governor's Offices, and state departments of education, human services, and justice. An estimated $340,000 for four awards is available and the close date for applications is May 1.

The announcement is available at *http://www.grants.gov/search/search.do?mode=VIEW&oppId=13038*. ♦

NASMD Position Announcements

Health Policy Analyst/Associate

American Public Human Services Association (APHSA) seeks experienced candidates to fill health policy analyst/associate positions working in its affiliate association, the National Association of State Medicaid Directors (NASMD). The staff members will be responsible for issue areas that include aging, disability, health care quality, behavioral health, and managed care. Staff will work on a daily basis with key Medicaid officials at the federal and state levels. The major areas of responsibility include:

- Serving as liaisons to congressional staff and administration officials regarding Medicaid policy, including assisting in the development and monitoring of national and state-level health care policies;
- Assisting in collecting and analyzing information regarding Medicaid programs and policies, and disseminating it to policymakers at the national and state levels;
- Promoting APHSA and NASMD policy by contributing to various publications; and
- Providing technical assistance and support to member agencies, including developing and analyzing state surveys.

Strong writing and communication skills and knowledge of health policy required. Hill or state Medicaid experience desirable. Ideal candidate will have advanced degree and 3-5 years of experience in specific policy area.

Email/fax resume with cover letter to: APHSA/Health Policy, 810 First Street, N.E. #500, WDC 20002 or *jobs@aphsa.org* or Fax: 202-289-6555. EEO/AA ♦

NASMD Internship Position

NASMD is currently accepting applications for an intern to work in Washington, DC. During the summer and fall of 2007.

INTERN RESPONSIBILITIES:

- Developing an online resources center of state innovations in Medicaid policy and programs
- Writing short articles for various NASMD publications, including weekly and monthly newsletters distributed to current and former Medicaid directors and their staff
- Attending Congressional hearings and meetings on Medicaid and health-related issues and tracking Medicaid related legislation
- Developing and analyzing surveys on a range of topics
- Updating NASMD listservs and contact information
- Assisting with website development
- Supporting staff in conference development and preparation
- Supporting staff in state-to-state technical assistance activities

Interns may be eligible to receive academic credit for their internship and/or to receive a small stipend per semester. Please send resume, letter of interest, and writing sample to Ashley Trantham at *atrantham@aphsa.org.* ♦

CALENDAR *Upcoming Conferences & Events*

Medicaid/SCHIP Dental Association Meeting

Held in conjunction with the National Oral Health Conference

April 30 – May 2, 2007
Denver, Colorado
For more information, please see visit *www.medicaiddental.org* or email *info@medicaiddental.org.*

Center for Workers with Disabilities Spring Meeting

May 14 – 15, 2007
Boston Park Plaza Hotel and Towers
64 Arlington Street
Boston, Massachusetts, 02116
617-426-2000

APHSA Spring Meeting (Rescheduled from March)

June 3 – 5, 2007
Hyatt Regency Capitol Hill
Washington, DC

Spring 2007 NASMD Meeting
June 11–12, 2007 • Sheraton Burlington Hotel & Conference Center Burlington, VT

Special New Member Orientation Sunday June 10

For more information please visit: ***http://www.nasmd.org/conf/conf.htm***

2007 Medicaid Management Information Systems (MMIS) Conference

August 12 – 16
San Diego Marriott Hotel and Marina
www.mmisconference.org

The 23rd National Home and Community Based Services Conference

September 30 – October 3, 2007
Hyatt Regency Albuquerque
Albuquerque, New Mexico
http://www.nasua.org/waiverconference/

APHSA Fall Meeting

September 9–11, 2007
Arlington, VA
http://www.aphsa.org/Conference/calendar.asp

2007 Fall NASMD Meeting

November 12–14, 2007
Hyatt Regency Capitol Hill
Washington, DC
For more information contact Ashley Trantham *atrantham@aphsa.org.*

CWD Annual Fall Meeting held in conjunction with the CMS Annual Medicaid Infrastructure Grant (MIG) Conference

November 14–16
Washington, DC
For more information contact Ashley Trantham *atrantham@aphsa.org.* ♦

COMINGS & GOINGS

Jim Edge has been named Acting State Medicaid Director for Oregon.

NASMD *Health Policy Staff Contacts*

NASMD is supported by a team of health policy professionals within APHSA's Policy & Government Affairs Division.

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Managed Care TAG, Systems TAG, SCHIP TAG, state issues and innovations, financing issues in Medicaid, Medicaid Medical Directors, SCHIP Dental Directors

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NASMD National Association of State Medicaid Directors
an affiliate of the American Public Human Services Association

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